SLS 10RS-680 **ENGROSSED**

Regular Session, 2010

SENATE BILL NO. 153

BY SENATOR ERDEY

HEALTH/ACC INSURANCE. Relative to the high risk health insurance pool. (gov sig)

AN ACT

To amend and reenact R.S. 22:1061(3)(d)(i), 1073(B)(4), 1210(D), (E), and (F), 1213, and to enact R.S. 22:1061(4)(k), 1205(C)(6) and (D), relative to the Louisiana Health Plan; to provide for compliance with federal law for expanded coverage by the plan; to redefine certain terms relative to portability, availability, and renewability of health insurance coverage; to provide with respect to coverage of mental and nervous conditions, including alcohol and substance abuse, by the plan; to provider with respect to initial rates for federally and non-federally defined eligible individuals; to delete the six-month preexisting condition provision for federally defined eligible individuals; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:1061(3)(d)(i), 1073(B)(4), 1210(D), (E), and (F), 1213 are hereby amended and reenacted and R.S. 22:1061(4)(k) and 1205(C)(6) and (D) are hereby enacted to read as follows:

§1061. Definitions

As used in R.S. 22:984 and 1061 through 1079, the following terms shall have the following meanings:

* * *

(3) "Excepted benefits" means benefits under one or more of the following:

* * *

(d) Benefits not subject to requirements if offered as a separate insurance policy:

(i) Medicare ~~coverage.~~ **supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act.**

* * *

(4) "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

* * *

(k) Medical assistance coverage provided under 42 USCA 1397 et seq.

* * *

§1073. Guaranteed availability of individual health insurance coverage to certain individuals with prior group or individual coverage

* * *

B. As used in this Section, the term "eligible individual" means an individual who meets the requirements of Subsection H of this Section or an individual:

* * *

(4) Who**,** ~~elected~~ **if offered the option of continuation of** coverage under a COBRA continuation provision or under a similar state program~~.~~**, elected this coverage.**

* * *

§1205. Plan of operation

* * *

C. In its plan of operation the board shall:

* * *

(6) Provide the details of the calculation of each participating insurer's assessment.

D. The board, with the approval of the commissioner, may establish, provide for, administer, and contract to provide coverage for a health plan to offer eligible individuals and families the ability to purchase or enroll in a program established under federal law that provides expanded coverage for state high risk pools.

* * *

§1210. Fees assessed to participating health insurers for plan losses attributable to federally defined eligible individuals

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D.**(1)** Each participating insurer's fee assessment shall be in the proportion to gross premiums earned on business in this state for policies or contracts covered under this Section for the most recent calendar year for which information is available.

~~E.~~ **(2)** Each participating insurer's fee assessment shall be determined by the board based on annual statements and other reports deemed to be necessary by the board and filed by the participating insurer with the board. The board may use any reasonable method of estimating the amount of gross premium of a participating insurer if the specific amount is unknown. **The plan of operation shall provide the details of the calculation of each participating insurer's assessment which shall require the approval of the commissioner.**

~~F.~~ **E.** A participating insurer may petition the commissioner of insurance for deferral of all or part of any fee assessed by the board. If, in the opinion of the commissioner, payment of the fee assessment would endanger the solvency of the participating insurer, the commissioner may defer, in whole or in part, the fee assessment as part of a voluntary rehabilitation or supervisory plan established to prevent the plan's insolvency. Any deferrals approved under a voluntary rehabilitation or supervisory plan shall be limited to four years and require repayment of all deferrals by the end of such period plus legal interest. Until notice of payment in full is received from the board, the insurer shall remain under the

voluntary rehabilitation or supervisory plan. In the event a fee assessment against a participating insurer is deferred in whole or in part, the amount by which the fee assessment is deferred may be assessed to the other participating insurers in a manner consistent with the basis for fee assessments set forth in this Section. Collection of such deferrals and legal interest shall be used to offset fee assessments against the other participating insurers in a manner consistent with the basis for fee assessments set forth in this Section.

* * *

§1213. Benefits; availability

A. The plan shall offer comprehensive coverage to every eligible person who is not eligible for Medicare and public programs as defined in this Subpart. Comprehensive coverage offered by the plan shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under Paragraph (4) of Subsection ~~F~~ **E** of this Section, up to a maximum lifetime benefit as established by the board of not less than five hundred thousand dollars per covered person, payable up to a maximum of two hundred fifty thousand dollars per covered person per twelve consecutive months of coverage. For federally defined eligible persons, the board shall establish benefits and maximum benefit amounts in accordance with applicable federal law and regulations.

B. ~~The board shall establish reasonable reimbursement amounts for the following services and articles prescribed by a health care provider and determined by the plan to be medically necessary, including but not limited to:~~ **Covered expenses shall be the usual, customary, and reasonable charge, as established by the board, in the locality for the following services and articles when prescribed by a physician and determined by the plan to be medically necessary for the following areas of services:**

(1) Hospital services.

(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions which are rendered by a health care provider or by other licensed

professionals at the direction of a health care provider.

(3) Services of a licensed skilled nursing facility for up to a maximum of one hundred twenty days per twelve consecutive months of coverage, unless extended for additional days under any cost containment program implemented by the board pursuant to Subsection ~~I~~ **H** of this Section.

(4) Services of a home health agency up to a maximum of two hundred seventy services per twelve consecutive months of coverage, unless increased under any cost containment program implemented by the board pursuant to Subsection ~~I~~ **H** of this Section.

(5) Use of radium or other radioactive materials.

(6) Oxygen.

(7) Anesthetics.

(8) Prostheses other than dental.

(9) Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the conditions for which it is prescribed.

(10) Diagnostic X-rays and laboratory tests.

(11) Oral surgery for excision of partially or completely unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of other teeth.

(12) Services of a physical therapist.

(13) Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition.

(14) Services for diagnosis and treatment of mental and nervous disorders provided that a covered person may be required to pay up to a fifty percent coinsurance payment, and the plan's payment may not exceed twenty-five thousand dollars. Notwithstanding the previous provision, the department may conduct a periodic actuarial cost analysis to determine whether the plan's maximum payment for outpatient services for diagnosis and treatment of

mental and nervous disorders should be adjusted.

C. The board shall establish reasonable reimbursement amounts for any services covered under the benefits plans which are not included in Subsection B of this Section.

D. ~~In the event the amounts charged for services and articles provided by or at the direction of a health care provider exceed the amount payable for covered expenses as provided herein, the health care provider may seek payment of the balance owed from the member as allowed under applicable contracts or state and federal laws and regulations.~~

~~E.~~ Covered expenses shall not include the following, except as mandated by applicable federal law for federally defined eligible individuals:

(1) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions.

(2) Care which is primarily for custodial purposes.

(3) Any charge for confinement in a private room to the extent surcharge is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician.

(4) That part of any charge for services rendered or articles prescribed by a physician, dentist, or other health care provider which exceeds the reasonable reimbursement amounts established in Subsections B and C of this Section or for any charge not medically necessary.

(5) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles.

(6) Any expense incurred prior to the effective date of coverage by the plan for the person on whose behalf the expense is incurred.

(7) Dental care except as provided in Subsection B of this Section.

(8) Eyeglasses and hearing aids.

(9) Illness or injury due to acts of war.

(10) Services of blood donors and any fee for failure to replace the first three pints of blood provided to an eligible person each policy year.

(11) Personal supplies or personal services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service.

~~(12) Any charge for the diagnosis and treatment of mental and nervous disorders, including alcohol and substance abuse.~~

~~F.~~ **E.**(1) Premiums charged for coverages issued by the plan may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage.

(2) Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks. Separate schedules of premium rates for federally defined eligible individuals may be based on age, sex, and geographical location, in accordance with applicable federal laws and regulations.

(3)**(a)** The plan**, with the assistance of the commissioner,** shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers offering coverages in the state comparable to the plan coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage.

(b) Standard risk rates for federally defined ~~eligibles~~ **eligible individuals** shall comply with all applicable federal laws and regulations. **Initial rates for plan coverage for federally defined eligible individuals shall not be less than one hundred twenty-five percent of rates established as applicable for individual standard risks. In no event shall plan rates exceed two hundred percent of rates applicable to the individual standard risks.**

(c) Initial rates for plan coverage provided to nonfederally defined eligible individuals shall not be less than one hundred fifty percent of rates established as applicable for individual standard risks, or the minimum monthly rates as provided

for herein, whichever is greater. Subsequent rates provided to nonfederally defined eligible individuals shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall plan rates exceed two hundred percent of rates applicable to individual standard risks. In no event shall rates be lower than one hundred ten percent of rates applicable to individual standard risks.

(4) The plan coverage defined in this Section shall provide benefits, deductibles, coinsurance, and copayments to be established by the board. In addition, the board may establish optional benefits, deductibles, coinsurance, and copayments.

~~G~~ **F.** Plan coverage provided to non-federally defined eligible individuals shall exclude charges or expenses incurred for or caused by preexisting conditions as allowed under R.S. 22:1073(A)(1)(b)~~.~~**, except that no preexisting condition exclusion shall be applied to a federally defined eligible individual.**

~~H.~~ **G.** (1) Notwithstanding any other law to the contrary, the coverage provided by the plan shall be considered excess coverage, and benefits otherwise payable under plan coverage shall be reduced by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment, or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable by any insurer or insurance arrangement or any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(2) The plan shall have a cause of action against an eligible person for the recovery of the amount of benefits paid by it which are not covered expenses. Benefits due from the plan may be reduced or refused as a set-off against any amount recoverable under this Paragraph.

~~I.~~ **H.** The benefits plan offered pursuant to this Section shall include such managed care provisions as the board deems necessary and proper for:

(1) Compliance with applicable federal laws and regulations regarding

choices of benefit coverage for federally defined eligible individuals.

(2) Containment of costs, including precertification and concurrent or continued stay review of hospital admissions, mandatory outpatient surgical procedures, preadmission testing, or any other provisions determined by the board to be cost effective and consistent with the purposes of this Subpart.

~~J.~~ **I.** Except as otherwise provided in this Subpart and in R.S. 22:976, this Section shall establish the exclusive means for determining the benefits required to be offered by the plan, notwithstanding any mandatory benefits or required policy provisions in this Title to the contrary.

Section 2. This Act shall become effective upon signature by the governor or, if not signed by the governor, upon expiration of the time for bills to become law without signature by the governor, as provided by Article III, Section 18 of the Constitution of Louisiana. If vetoed by the governor and subsequently approved by the legislature, this Act shall become effective on the day following such approval.

The original instrument was prepared by Cheryl Horne. The following digest, which does not constitute a part of the legislative instrument, was prepared by Thomas L. Tyler.

DIGEST

Erdey (SB 153)

Proposed law redefines certain terms for purposes of present law relative to assuring portability, availability, and renewability of health insurance coverage, administered in part by the La. Health Plan, as follows:

(1) Deletes Medicare coverage benefits from the definition of those"excepted benefits" not subject to requirements if offered as a separate insurance policy and adds Medicare supplemental health insurance benefits as defined by the federal Social Security Act.

(2) Includes under the definition of "creditable coverage" certain medical assistance coverage provided under federal law.

(3) Changes the definition of "eligible individual" from an individual who elected COBRA continuation or a similar state program to an individual who, if offered the option of continuation of COBRA coverage or a similar state program, elected this coverage.

Proposed law requires the board of directors of the plan to provide the details of the calculation of each participating insurer's assessment in its plan of operation which is submitted to the commissioner of insurance for his approval. Further authorizes the board, with the approval of the commissioner, to establish, provide for, administer, and contract to

provide coverage for a health plan to offer eligible individuals and families the ability to purchase or enroll in a program established under federal law that provides expanded coverage for state high risk pools.

Present law requires the board to establish reasonable reimbursement amounts for health care services and providers determined by the plan to be medically necessary, including but not limited to a list of services specified.

Proposed law provides that covered expenses include the usual, customary, and reasonable charge, as established by the board, in the locality for services specified in present law when prescribed by a physician and determined by the plan to be medically necessary for the areas of services specified.

Present law excludes from covered expenses, unless mandated by federal law for federally defined eligible individuals, any charge for the diagnosis and treatment of mental and nervous disorders, including alcohol and substance abuse. Proposed law removes this specific exclusion.

Proposed law provides that covered expenses includes services for diagnosis and treatment of mental and nervous disorders, but provides that the covered person may be required to pay up to a 50% coinsurance payment and that the plan's payment may not exceed $25,000. Authorizes the Department of Insurance to conduct a periodic actuarial cost analysis to determine whether the plan's maximum payment for outpatient services for diagnosis and treatment of mental and nervous disorders should be adjusted.

Present law provides that if the amount charged for services provided by or at the direction of a health care provider exceed the amount payable for covered expenses by the plan, the health care provider may seek amounts payable for covered expenses from the member as allowed under applicable contracts or state and federal laws and regulations. Proposed law deletes these provisions.

Present law requires that the plan determine the standard risk rate by calculating the average individual standard rate for the five largest insurers offering coverage in the state comparable to the plan coverage. Proposed law provides that his determination be made with the assistance of the commissioner of insurance.

Present law provides that standard risk rates for federally defined eligibles comply with federal law and regulations. Proposed law retains this provision but provides that initial rates for plan coverage for such individuals not be less than 125% and not more than 200% of standard risk rates applicable to individuals.

Present law provides that initial rates for plan coverage provided to non-federally defined eligible individuals shall not be less than 150% of rates established as applicable for individual standard risks, or the minimum monthly rates as provided for in present law, whichever is greater. Requires that subsequent rates provided to such individuals shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in present law. Specifies that in no event shall plan rates exceed 200% of rates applicable to individual standard risks or shall rates be lower than 110% of rates applicable to individual standard risks. Proposed law retains these provisions.

Present law allows a six-month pre-existing condition provision to be applied to non-federally qualified individuals. Proposed law retains these provisions but provides that no pre-existing condition be applied to federally defined eligible individuals.

Effective upon signature of governor or lapse of time for gubernatorial action.

(Amends R.S. 22:1061(3)(d)(i), 1073(B)(4), 1210(D), (E), and (F), 1213; and adds R.S. 22:1061(4)(k), 1205(C)(6) and (D), and 1213(B)(14))

Summary of Amendments Adopted by Senate

Committee Amendments Proposed by Senate Committee on Insurance to the original bill.

1. Reinstates provisions regarding the initial rates for non-federally defined eligible individuals.